ConnectiCare

Small Group Market
Choice Mass HMO HSA $3000/$6000
HMO Open Access Contract Year Plan
High Deductible Health Plan (HDHP) for use with a Health Savings Account (E)
Benefit Summary
Non-Tiered Network Plan

The individual deductible and out-of-pocket maximum applies if you have coverage only for yourself. The family deductible and out-of-pocket maximum applies if you have coverage for yourself and one or more eligible dependents. Each individual on the family plan will only need to satisfy the individual deductible and out-of-pocket maximum, not the full family amount. Each individual's charges will accrue towards the family amounts.

✔ This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please refer to the "Important Information" section of this Benefit Summary for additional information.

Deductible and Out-of-Pocket Maximum	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Plan deductible	$3,000 per member $6,000 per family	N/A per member N/A per family
Separate Prescription Drug Deductible	None	N/A per member N/A per family
Out-of-Pocket Maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$6,500 per member $13,000 per family	N/A per member N/A per family
Benefits	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Provider Office Visits		
Adult/Pediatric Preventive Visits	No charge	Not covered
Primary Care Provider Office/ Telemedicine Visits includes services for illness, injury, follow-up care and consultations	$25 copayment/visit after plan deductible	Not covered
Telemedicine Services services rendered by a Teladoc® provider	0% coinsurance after plan deductible	Not covered
Specialist Office/Telemedicine Visits	$50 copayment/visit after plan deductible	Not covered
Mental Health and Substance Abuse Office Visits	$25 copayment/visit after plan deductible	Not covered
Outpatient Diagnostic Services		

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Advanced Radiology CT/PET Scan, MRI	$75 copayment/visit after plan deductible	Not covered
Laboratory Services	$15 copayment/visit after plan deductible	Not covered
Non-Advanced Radiology X-ray, Diagnostic	$50 copayment/visit after plan deductible	Not covered
Prescription Drugs – Retail Pharmacy (cost share based on 30 day supply per prescription)		
Preferred Generic Tier 1	$25 copayment/prescription after plan deductible	Not covered
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $300 per prescription after plan deductible	Not covered
Preferred Brand Tier 3	$40 copayment/prescription after plan deductible	Not covered
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $300 per prescription after plan deductible	Not covered
Specialty Drugs – (cost share up to 30 day supply per prescription - These drugs generally require pre-authorization and may require special handling)		
Preferred Specialty Tier 5	50% coinsurance up to a maximum of $250 per prescription after plan deductible (specialty retail only)	Not covered
Non-Preferred Specialty Tier 6	50% coinsurance up to a maximum of $750 per prescription after plan deductible (specialty retail only)	Not covered
Prescription – Mail Order Pharmacy (up to a 90 day supply per prescription)		
Preferred Generic Tier 1	$50 copayment/prescription after plan deductible	Not covered
Non-preferred Generic Tier 2	50% coinsurance up to a maximum of $600 per prescription after plan deductible	Not covered
Preferred Brand Tier 3	$80 copayment/prescription after plan deductible	Not covered
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $600 per prescription after plan deductible	Not covered

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Outpatient Rehabilitative and Habilitative Services 60 visits per contract year limit combined for physical and occupational therapies. Separate 60 visits per contract year limit combined for Habilitative physical and occupational therapies.		
Speech Therapy	$50 copayment/visit after plan deductible	Not covered
Physical and Occupational Therapy up to 60 visits per year (includes services combined for physical and occupational therapy) Speech and hearing therapy, prescribed by applicable law, apply to, but are not limited by the visit maximum	$50 copayment/visit after plan deductible	Not covered
Other Services		
Chiropractic Services up to 20 visits per year	$50 copayment/visit after plan deductible	Not covered
Diabetic Equipment and Supplies	20% coinsurance after plan deductible	Not covered
Durable Medical Equipment (DME)	20% coinsurance after plan deductible	Not covered
Home Health Care Services	0% coinsurance after plan deductible	Not covered
Outpatient Services in a hospital or ambulatory facility	$100 copayment/visit after plan deductible	Not covered
Inpatient Services		
Inpatient hospital services include mental health, substance abuse, maternity, hospice, skilled nursing facility* and all IP settings.*skilled nursing facility stay is limited to 100 days per contract year	$100 copayment/day up to $400 per admission after plan deductible	Not covered
Emergency and Urgent Care		
Ambulance Services	$250 copayment/service after plan deductible	Same as In-network benefit
Emergency Room copayment waived if admitted	$250 copayment/visit after plan deductible	Same as In-network benefit
Urgent Care Centers	$75 copayment/visit after plan deductible	Same as In-network benefit
Pediatric Dental Care (for children under age 20)		
Diagnostic & Preventive	No charge	Not covered

Benefits	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Basic Services	50% coinsurance after plan deductible	Not covered
Major Services	50% coinsurance after plan deductible	Not covered
Orthodontia Services medically necessary only	50% coinsurance after plan deductible	Not covered
Pediatric Vision Care (for children under age 20)		
Prescription Eye Glasses one pair of frames and lenses per year	Lenses: $50 after plan deductible Collection frames: $50 after plan deductible Non-collection frames: $50 after plan deductible up to the collection frame allowance; any amount over is payable by the member minus a 20% discount	Not covered
Routine Eye Exam by a Specialist up to one visit per year	$25 copayment/visit; deductible does not apply	Not covered
Additional Covered Services		
Adult Routine Eye Exam by a Specialist - over age 20 up to one visit per year	$25 copayment/visit; deductible does not apply	Not covered
Allergy Injections up to 20 visits per year	See primary care or specialist services	Not covered
Allergy Testing up to one visit per year	See primary care or specialist services	Not covered
Artificial Limbs includes associated supplies and equipment	20% coinsurance after plan deductible	Not covered
Inpatient Physician Services	0% coinsurance after plan deductible	Not covered
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	$100 copayment/visit after plan deductible	Not covered
Retail Clinic	$25 copayment/visit after plan deductible	Not covered

Important information

- This is a brief summary of benefits. Refer to your Membership Agreement for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described are per member per Contract year.
- If you have questions regarding your plan, visit our website at www.connecticare.com or call us at (860) 674-5757 or 1-800-251-7722.
- To learn more about your **Teladoc®** benefits contact **Teladoc®** at teladoc.com/connecticare or call 1-800-835-2362 (TTY: 711).
- Under this program covered prescription drugs and supplies are put into categories (i.e., tiers) to designate how they are to be covered and the member's cost-share. The placement of a drug or supply into one of the tiers is determined by the ConnectiCare Pharmacy Services Department and approved by the ConnectiCare Pharmacy & Therapeutics Committee based on the drug's or supply's clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.
- Most Specialty drugs are dispensed through Specialty Pharmacies by mail, up to a 30-day supply. Specialty Pharmacies have the same Member Cost Share as all other participating pharmacies and are not part of ConnectiCare's Voluntary Mail Order program. The Member Cost Share for Specialty Pharmacy is different from the Cost Share for ConnectiCare's Mail Order program.

Massachusetts Requirement to Purchase Health Insurance

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents 18 years of age and older, must have health insurance coverage that meets the Minimum Creditable Coverage standards set forth by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability of individual hardship. For more information call Connector at 1-877-MA-ENROLL or visit the Connector website www.mahealthconnector.org.

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2022, as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2022. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.